SECTION A

Question 1. **You must answer this question.**

The following passage describes what is recorded when a patient is admitted to hospital for medical care.

A community doctor refers the patient to the hospital. The hospital checks the patient's name, address, date of birth, and patient number in its patient file. Each hospital admission is known as an admission episode; it begins with a reason for admission and a planned admission date being recorded when a community doctor refers the patient. The patient is sent an admission card and this card is copied to the community doctor. Each admission episode ends when the patient is discharged; the reason for discharge and the discharge date are recorded on the admission episode file. The community doctor is sent discharge notes prepared by the hospital doctor. The patient receives discharge advice. A hospital doctor supervises each admission episode and a hospital doctor supervises many admission episodes. The hospital doctor reports any treatment that is to be undertaken by the patient and this is recorded for the episode.

When the hospital doctor makes a diagnosis, the description of the diagnosis and the diagnosis code is written on the patient file with the date; over time a patient can have many diagnoses recorded. Each admission episode entails the possibility of treatment for the diagnosis. The treatment can be composed of surgery, medication, or both. For surgery the date of the surgical operation, the surgery code, and a description is recorded. For medication the following are recorded: drug name and its code, the dose, start date, frequency and notes.

An admission episode is created when a community doctor refers the patient; this is called a planned admission. If the community doctor reports that the patient's circumstances have changed (eg the patient recovers) then the admission can be cancelled and this becomes a cancelled admission; the cancellation date and reason are recorded. Upon reading the patient details, the hospital doctor offers a planned admission date to the patient. If the hospital doctor reports the need delay a planned episode it becomes a deferred admission and the patient is advised of the delay as is the community doctor; the length of delay is recorded. A delayed admission can be cancelled. When a patient enters hospital, the admission is regarded as being activated and the admission date recorded. If no diagnosis is made or if the diagnosis is not treatable then the patient is discharged from hospital; the admission episode is completed and called a discharged admission. If the patient has treatable diagnoses then the admission is regarded as treatable and the admission episode is marked accordingly. While different treatments are carried out the admission continues to be called treatable. When the treatment cycle is completed the patient is discharged; the discharge date and reason for discharge are written on the episode. The discharge is the final state of admission episode.

There are two types of doctor involved in the care of a patient. Both types of doctor have a doctor number, a medical qualification, and a name. The hospital doctor supervises each admission episode and is responsible for discharging the patient. For the hospital doctor we record the ward/clinic and the specialty the doctor responsible for. The community doctor refers the patient in the first place. For the community doctor we record the practice address, postcode, telephone number, and fax number. A hospital doctor can never be a community doctor as well.